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Health Care and the Limits of “Progressive” Neoliberalism: Re-Evaluating the Trade-Health Interface 2006-2019

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01. Introduction

1 In the decade following the passage of the North American Free Trade Agreement (NAFTA) in 1994 and the inception of the World Trade Organization (WTO) in 1995, Canadians confronted a new layer of complexity and uncertainty affecting health care policy and health care reform. At the same time that federal transfers were being limited to balance the federal budget and reduce the national public debt, several government bodies were considering the growing fiscal, demographic, technological, and other challenges to health care policy. In 2002, several key reports on the future of health care were released, each of which outlined visions for reforming the Canadian health care system: those of the Commission on the Future of Health Care in Canada or Romanow Report; the Standing Senate Committee on the State of the Health Care System or Kirby Report; and the Government of Alberta Premier's Advisory Council on Health or Mazankowski Report. Although the Romanow Report emphasized steps to improve the sustainability of the existing system, the Kirby Committee drew attention to the possible benefits of more competitive health care delivery models, while the Mazankowski Report and the Alberta government even signaled a willingness to consider diverse private funding and payment models, making frequent reference to the need for greater competition and consumer choice. Notwithstanding concerns about health care costs growing approximately twice as fast as the economy, lack of

coverage for drugs and home care for an aging population, and lengthening wait lists for surgery, federal Liberal governments during this period stressed the protection of universal single-payer health care for essential health services, even announcing (once the federal budget had been balanced) a huge increase in health transfers in 2004 when prime minister Paul Martin brought in what he called a "fix for a generation" with his 10-year, $41-billion Health Accord. Yet at the same time, successive federal governments of both Liberal and Conservative stripes were also working to better institutionalize economic neoliberalism and limit the policy autonomy of states through international economic agreements.

2 Many commentators observed an incompatibility in the respective logics of our purportedly steadfast health care policies and the newly accepted principles of trade liberalization that prevailed after the Free Trade election of 1988. Canada, inspired by the example of Saskatchewan and encouraged by the federal government's 1957 *Hospital Insurance and Diagnostic Services Act* (that reimbursed one-half of provincial and territorial costs for hospital and diagnostic services administered under provincial and territorial health insurance programs) and the 1966 *Medical Care Act* (which expanded the HIDS Act expense-sharing, allowing each province and territory to initiate a universal public health care plan), established a public sector health insurance monopoly for “medically essential services” provided by (largely private, fee-for-service) physicians and (largely not-for-profit, globally funded) hospitals. Since the 1984 *Canada Health Act* (CHA) regulates who can provide healthcare by prohibiting commercial insurance coverage of hospital and physician services covered by medicare, and discouraging extra-billing and user fees, it cuts against the grain of "free trade," which aims to optimize competitive market conditions by opening markets to all investors and providers of goods and services. The former restricts the commercial opportunities available to private investors and services providers; the latter enables and promotes them by limiting at least certain forms of (trade-restrictive) government regulation.

3 The Canadian Liberal governments between 1993 and 2006, which oversaw the implementation in Canada of the North American Free Trade Agreement (NAFTA) and the World Trade Organization (WTO)'s General Agreement in Trade in Services (GATS), as well as participating in the stalled negotiations of both the Doha Development Round at the WTO and the Free Trade Agreement of the Americas (FTAA), had two main strategies for achieving and communicating about the balance between trade agreements and health. First, it emphasized the basic principles of non-discrimination in trade, i.e. Most-Favoured Nation (MFN), by which all members are granted the same market access as the most favored member; and National Treatment (NT), which treats all exporting firms the same as firms in the importing country, challenging trade critics and skeptics to show how following these basic principles could harmfully constrain existing healthcare policies and priorities. Second, successive governments emphasized additional legal safeguards designed to shield the health sector from trade rules, such as reservations placed in Canada's schedules of commitments, and exclusion clauses (or "carve-outs") designed to explicitly exempt health-related policies and activities from coverage in trade agreements. Examples of the former include standard exclusions of health and public education services from negotiated services agreements, such as GATS. Examples of the latter include the GATS Article 1:3 exception of services “supplied in the exercise of governmental authority”, and the Social Service

Reservation contained in Annex II of the NAFTA. A consistent message of the Canadian government during both the NAFTA and WTO/GATS negotiations was that healthcare was “off the table” (DFAIT 2000).

4 Each of these strategies however had distinct limitations. First, the evolution of the international trade agenda beyond the earlier GATT’s focus on conventional tariffs and non-tariff barriers on goods has raised doubts about the effectiveness of traditional protections: in particular, the negotiation of services trade liberalization, government procurement, domestic regulations, and especially the negotiation of trade-related intellectual property and investment protection (TRIPs and TRIMs). Secondly, the effectiveness of legal safeguards in exempting or carving out areas of health policy has been dependent upon the nature of healthcare policies themselves, since the protection afforded by exemption clauses and careful scheduling of commitments shrinks with the expansion of market elements in health care. Hence the need to assess the trade agreement-related risks associated with health policy change has grown commensurately with market-based health care reforms.

5 Canada’s willingness to experiment with market-based health care reform has been greatly constrained by the general popularity of medicare’s principles as enshrined in the CHA, coupled with intensive lobbying and publicity on the part of health advocates, including medical, economic, and policy experts who point out the high cost and tendency to market failure in private health insurance and for-profit health care in the United States. Nevertheless, growing dissatisfaction with the performance of certain aspects of the Canadian system, particularly concerning surgery and diagnostic wait times, have not often prompted governments to provide better access to health care for all Canadians, either. Several provincial governments, whether for reasons of ideological preference or fiscal strain, have shown a growing willingness to allow the spread of private clinics and the contracting out or reduction of several diagnostic and treatment services. Moreover, the Conservative federal government from 2006 to 2015, in keeping with both its spirit of ‘Open Federalism’ and its pro-market ideology, was not particularly zealous or threatening in its enforcement of the *Canada Health Act*. Besides, there has been growing recourse to the courts: in particular, constitutional challenges to overturn present legal restrictions on privately financed care.[1] *Chaoulli v. Quebec*[2], as the first successful challenge to the ban on private health insurance of medically necessary care to be decided in the Supreme Court of Canada, opened the door to privately financed essential medical services in cases where reasonable wait times were not being achieved. This has also spawned a further case, *Cambie Surgeries v. British Columbia*[3], which challenged the ban on doctors practicing in both public and private systems and the ban on extra-billing (the key enforcement provision of the *Canada Health Act*). Although this attempt to extend the scope of the *Chaoulli* ruling was unsuccessful in the B.C. Supreme Court in 2020, it is expected to be appealed to the Supreme Court of Canada.

02. From Broad to Narrow Exemptions

6 Besides these modest movements toward privatization at the domestic legal and policy level, there were more dramatic developments on the international trade front. The Harper government built its foreign policy around economic diplomacy and signing a large number of bilateral and plurilateral trade and investment agreements. The

Comprehensive Economic and Trade Agreement (CETA), largely negotiated under the Conservatives but concluded under the Liberals, is illustrative. It contains in Section 28 a list of “Exceptions” that includes the following statement: “The Parties understand that the measures referred to in Article XX (b) of the GATT 1994 include environmental measures necessary to protect human, animal or plant life or health”. This standard clause (which both Canada and the EU had already adopted by being signatories to the GATT 1994) helps to preserve a basic minimum of policy autonomy to regulate food safety and maintain public health but does not afford any added protection.

7 CETA does not contain an exact equivalent to either the GATS Article I:3 "Governmental Authority" Exemption (excluding from the most basic MFN and transparency obligations for services "supplied in the exercise of governmental authority"), or the NAFTA Annex II Social Service Reservation. Instead, it contains a "Joint Interpretive Instrument", section 2 of which affirms both Canada's and the EU's right to regulate: "CETA reserves the ability of the European Union and its Member States and Canada to adopt and apply their laws and regulations that regulate economic activity in the public interest, to achieve legitimate public policy objectives such as the protection and promotion of public health, social services, public education, safety." This shelters government policy capacity from the other provisions of the agreement, but does not guarantee that any such policy space can be reclaimed once it has been opened to commercial activity. Similarly, Section 4 of CETA “does not prevent governments from defining and regulating the provision of these services in the public interest. CETA will not require governments to privatize any service nor prevent governments from expanding the range of services they supply to the public.” But left unstated are the likely obligations that would be incurred if such expansion interfered with private market activity. Furthermore, Article 9.2(a) of the Chapter on Cross-Border Services echoes the language of the GATS Article 1:3 in stating that “[t]his chapter does not apply to a measure affecting... services supplied in the exercise of governmental authority"; like the GATS Article 1:3, this is likely to be interpreted to not cover public services delivered competitively or commercially. While health and medical services are not explicitly mentioned in the list of professions contained in Annex 19-5 list of services open to government procurement, neither is there any attempt to exclude cleaning, human resources, or management services related to health; nor is there any health exception contained in any of the (admittedly non-binding) guidelines for Mutual Recognition Agreements (MRAs) of professional credentials. Indeed, it is unsurprising that Canada did not seek to strengthen or broaden its public services exemptions as compared to NAFTA or GATS, given the Harper government’s status as a *demandeur* in the negotiations, and an ideologically conservative one at that.

8 These sections and those on Labour and Environmental protection in Chapters 23 and 24 (which do not set specific minimal standards that must be met, but merely affirm the governments’ right to make policy in these areas) must be balanced with CETA’s much stronger commitment to institutionalizing Investment Protection and Patents: Chapter 20 explicitly “complements the rights and obligations between parties under the TRIPS Agreement” (which already requires signatories to implement 20 years of patent protection enforced by criminal sanctions), and sets out an additional period of protection for eligible pharmaceutical products (Article 20.27 sets out the *sui generis* protection for “basic” pharmaceutical patents-- a maximum period of two years in Canada’s case); an agreement “to ensure that all litigants are afforded equivalent and

effective rights of appeal under patent linkage regimes”; and an agreement to ensure eight years of protection for data filed with regulators as part of a regulatory approval process.

9 Likewise, the Comprehensive and Progressive Agreement for Trans-Pacific Partnership (CPTPP) contains the standard Sanitary and Phytosanitary (SPS) clause which maintains “the rights of parties to take measures necessary for the protection of human, animal or plant life or health, provided that such measures are based on scientific principles,” but the scope of the clause is carefully circumscribed. Although the CPTPP’s Investor-State Dispute Settlement provisions are not as extensive as they were under the original Trans-Pacific Partnership that included the United States, the CPTPP SPS chapter 7.2 (d) is intended to "help ensure that CPTPP market access gains for Canadian agricultural and agri-food, fish, seafood and forestry exports are not undermined by unnecessary or unjustified SPS-related trade restrictions." This chapter is noteworthy for the way it singles out (the normally uncontroversial) sanitary and phytosanitary measures as requiring special disciplines to not "create unjustified obstacles to trade." The CPTPP fails to explicitly recognize either the need to address climate change (which may necessitate major new policies with health implications) in the environment chapter, or the need for new public health measures, such as those that subsequently arose related to COVID-19 and other possible pandemics.

10 Instead of broad exemptions for a public authority in the CPTPP, we find affirmations of each party's "sovereign right to identify its regulatory priorities", coupled with an injunction towards "Regulatory Coherence", which is defined as " the use of good regulatory practices in the process of planning, designing, issuing, implementing and reviewing regulatory measures to facilitate achievement of domestic policy objectives, and in efforts across governments to enhance regulatory cooperation to further those objectives and promote international trade and investment, economic growth and employment"(Article 25.2). Whether Regulatory Coherence is a flexible enough concept to help rather than hinder governmental responses to climate change, pandemics, and other public health-related exigencies of the twenty-first century is an important question. There are reasons, however, to be skeptical, since the regulatory cooperation commitment refers to a common process whereby each country's policies will be constrained by what is negotiated under the terms of what are essentially commercial (trade and investment) agreements with the other parties.

11 Table 1 lists the trade treaty provisions most relevant to shielding health care jurisdiction from the regulation of international trade in Canada in the 11 trade treaties signed during the Harper Conservative and Trudeau Liberal governments between 2006 and 2019. All these Free Trade Agreements (FTAs) and Foreign Investment Promotion and Protection Agreements (FIPAs) begin with GATT preambles in which, for example, parties commit to "preserve their flexibility to safeguard the public welfare" and affirm "the rights to use, to the full, the flexibilities established in the TRIPS Agreement including those to protect public health and, in particular, those to promote access to medicines for all". However, while these general statements are a guide to interpreting the Agreement, they are also set alongside and must be balanced with, many other statements that commit the parties to "reduce distortions of trade", "enhance competitiveness", "promote economic integration", and so on.

12 Under the original General Agreement on Trade and Tariffs (GATT), there were several provisions obligating Members not to engage in discriminatory trade practices that

serve to block imports, such as Article I (Most-Favoured Nation or MFN); Article III (4) (National Treatment); and Article VI (Anti-Dumping and Countervailing Duties). Article XX, which listed ten general exceptions that governments could use to justify import restrictions, has acted as a 'safety valve' which allows the Member States to balance their policy goals with free trade. For example, in the 1990 Thai *Cigarettes* case, the government of Thailand was afforded a “margin of appreciation” under Article XX to ban imports of cigarettes, even though less trade-restrictive measures were available, but in the *Brazil Tyres* case (2007), Brazil's ban of retreaded tires from Europe (in favor of retreaded tires from Brazil that had the same effect of serving as breeding grounds for mosquitoes) was not upheld (Trebilcock 2015, 150-155). Of course, this case law merely dealt with a limited number of general exceptions to import bans; the SPS Agreement covered a broader range of potential measures applied to protect animal or plant life or health within the territory of a member based on scientifically-evaluated risks (Epps 2008).

13 Nevertheless, while the adoption of both Article XX and SPS is a standard feature of all of Canada's trade and investment agreements, they hardly touch the main features of domestic health policy frameworks: social insurance; payment and delivery systems; institutional and human resource roles; and breadth of coverage. Yet the agenda of international economic agreements have increasingly impacted each of these areas at precisely the time when new general carve-outs such as the NAFTA Reservation and Article 1:3 are being used less often. Table 1 shows a greater enthusiasm for specific Non-Derogation clauses (i.e. treaty provisions that explicitly guarantee that certain laws and regulations will not be waived or otherwise derogated from to encourage trade or investment) during the Harper minority years, for example, Article 11 of the Canada-Peru FIPA of 2008 and the Canada-Jordan FIPA of 2009. In these mini-carve-outs, “the Parties recognize that it is inappropriate to encourage investment by relaxing domestic health, safety or environmental measures.” They represent an exception to the trend towards legal limitations that must be balanced or harmonized with market imperatives, as opposed to being simply reserved to the public sphere. Their disappearance from the later FIPAs with Panama (2010) and Ukraine (2015) reflects a deeper commitment to strengthening investment guarantees in bilateral FTAs and BITs than has been achievable in multilateral contexts, such as the stalled Doha Round of the WTO (2001-2006) or the proposed Trade in Services Agreement (2014-present). The Government of Canada also touts “[t]he development and implementation of trade-related Labour Cooperation Agreements (LCAs) and Labour Chapters of Free Trade Agreements (LCFTAs)”,[4] which affects work-related health and safety, but these provisions typically only commit each party to not "waive or derogate from" its own labour laws in a manner "that weakens or reduces adherence to the internationally recognized labor principles and rights" and mandates consultations and a Review Panel in the event of a complaint.

14 One can find fairly broad NAFTA-like social service reservations within particular sectors, such as government procurement. The Annex 5 Reservation in the Canada-Panama FIPA, for example, excludes “all classes” of health and social service from national treatment in tendering of procurement for government purposes; the Canada-Korea FTA contains an even broader reservation for all types of future measures in Social Services. In the Annex II Schedule of the Canada-Peru FTA, for example, Canada does state, concerning Cross-Border Trade in Services And Investment, that it "reserves the right to adopt or maintain any measure for the provision of public law enforcement

and correctional services, and the following services to the extent that they are social services established or maintained for a public purpose: income security or insurance, social security or insurance, social welfare, public education, public training, health, and child care." Very similar reservations appear in the Schedules of the Free Trade Agreements with Panama, Honduras, Ukraine, and Korea as well.

15 The continuation of the general Social Services Reservation in the renewed NAFTA or Canada-US-Mexico (CUSMA) in 2018 was deemed essential to maintaining public support for the deal, and should not be construed as a sign of a general trend back towards broader exemptions. Article 9.2 of the CETA concerns the scope of cross-border trade in services and incorporates the familiar GATS language of excluding “services supplied in the exercise of governmental authority,” defined as “any service that is not supplied on a commercial basis, or in competition with one or more service suppliers." This does not protect health services that are supplied on a competitive market basis, even when there is a single public payer, and given the lack of any additional health-related reservations or non-derogation clauses in the Agreement, health care protection is therefore not particularly broad or robust. While the use of non-derogation clauses and health-related reservations between 2008 and 2015 initially looked promising as a substitute for broad general exemptions, there is an evident preference among treaty negotiators and the business community to make international trade and investment law free of encumbrances other than compliance with the basic GATT Article XX and SPS standards.

Table 1. 11 Trade Deals Signed Between 2006 and 2019

FTA/Date Signed	Basic WTO Standards (Preamble, Art.XX (b) of GATT) excepting measures "necessary to protect human, animal or plant life or health";	SPS (Sanitary & Phytosanitary) Agreement "applied only to the extent necessary to protect human, animal or plant life or health... based on scientific principles."	Non-derogation from health safety and environment (HSE) standards	Health-related Reservations	General GATS & NAFTA exemptions
Canada-European FTA/ Jan 2008	X	X	---	---	---
Canada-Peru FTA(&FIPA)/May 2008	X	X	X (Art.11 FIPA) "a Party should not waive or otherwise derogate from... such measures"	X (Annex 2) "Social Services"	--
Canada-Colombia FTA /Nov 2008	X	X	X (in side agreements, e.g. Art. 2 of LCA)	--	--
Canada-Jordan FTA (&FIPA) /June 2009	X	X	X (Art.11 FIPA and Art. 2 of LCA))	—	--
Canada-Panama FTA (&FIPA) /May 2010	X	X	(Art. 2 of LCA)	X (Annex 5) excludes "all classes" of health and social service from gov't procurement	--
Canada-Honduras FTA /Nov. 2013	X	X	(Art. 2 of LCA)	X (Annex 2) "Social Services"	--
Canada-Korea (CKFTA) / Mar. 2014	X	X	(Art.18.3 LCFTA)	X (Annex 2) "Social Services"	--

Canada-Ukraine /July 2015	X	X		X (Annex 1 of FIPA)	--
Comprehensive Economic and TA (CETA) / Oct. 2016	X	X			**Partial (Art.9.2) i.e. "services supplied in exercise of governmental authority."**
Comprehensive and Progressive Agreement for TPP (or CPTPP) / Mar. 2008	X	X	--	--	---
Canada-US-Mexico (CUSMA or USMCA) / Nov 2018	X	X		--	**NAFTA SSR continued in Annex II**

Source: https://www.international.gc.ca/trade-commerce/trade-agreements-accords-commerciaux/agr-acc/index.aspx?lang=eng

Source: https://www.international.gc.ca/trade-commerce/trade-agreements-accords-commerciaux/agr-acc/index.aspx?lang=eng

16 The CPTPP states in its preamble that the parties "recognize further their inherent right to adopt, maintain or modify health care systems"; and it contains commitments to "reinforce and build on the (WTO) SPS Agreement", as well as the standard GATT xx(b) allowance for "environmental measures to protect...health", but these are generally only relevant to basic Public Health rather than the design or delivery of health care. Furthermore, Chapter 25 on "Regulatory Coherence" defines "good regulatory practices" as those which further policy objectives and promote international trade and investment, economic growth, and employment." (25.2.1). Gone are the general exemptions of an earlier generation of agreements and, with them, the implicit claim that there is a large zone of democratic governance that does not have to be balanced or rendered coherent with the goals and objectives of the liberal trade regime. Occasional partial exceptions to this rule are provisions like the CETA Art. 9 (2), which explicitly adopts the language of the GATS Article 1:3 in stating that the Chapter on services trade does not apply to “services supplied in the exercise of governmental authority”.

17 The new Canada–U.S.-Mexico Agreement (CUSMA) continues to have the Annex II reservation for health, but its precise meaning and scope remain uncertain. The Office of the U.S. Trade Representative has expressed a very narrow interpretation of the clause, suggesting that any private or commercial elements in a health service could cause it to fall outside of the exemption. Although NAFTA/CUSMA dispute resolution is more likely to follow the international practice that emphasizes public funding and takes a somewhat more relaxed view of private delivery (Crawford 2006), concerns expressed by several critics and commentators during the development and implementation of the Canada-US FTA and NAFTA have been validated (Epps and Flood 2002; McBride 2005). The degree of government control over service delivery, and public funding, as well as the degree of government regulatory control and clearly, expressed public purpose, are all factors that a trade dispute panel is likely to take into account in determining whether a particular measure is a public service delivered for public purposes. Although US, Mexican, and other foreign corporations have only a

modest financial stake in Canada’s health care sector, thereby diminishing the risk of foreign investor claims, Canadian companies can always exploit the loophole revealed by the Abitibi-Bowater NAFTA case and file claims through their U.S. or Mexican subsidiaries. And if foreign suppliers ever do establish a strong commercial presence in the health sector, it will be very difficult to reverse market concessions and avoid the threat of future claims (Sanger, Shrybman, and Lexchin 204, 222).

18 It can still be argued that we should not be alarmed by the steady diminution in the scope and frequency of health-related carve-outs, or by the demise of general exemption clauses in the recent bilateral and plurilateral trade and investment agreements. In the first place, even the GATS exemption and the NAFTA Social Services Reservation applying to the investment and services chapters are not true, "pure" exemptions: they placed public services outside of the trade regime only if a threshold of commercial elements in payment and or delivery of services was not exceeded (see discussion of payment and delivery reform below). Moreover, there has not been as much legal mobilization to test the limits of these clauses as many had expected, and there has arguably not been enough privatization or commercialization (the Chaoulli case notwithstanding) to cause the main aspects of the health care system to fall outside of their scope. If there are reasons to worry about trade liberalization and health care, they may arise principally elsewhere, e.g. in the implications of entrenched intellectual property and investment rights for drug and technology costs. Nevertheless, trade treaty obligations may become much more consequential if there is a major change in the scope of medicare–such as a major shift towards privatization of health care financing or delivery, or an expansion to include pharmacare, nursing homes, home care, dental care, physiotherapy, etc. Rising costs and a climate of austerity in recent decades has meant that there has been little expansion of the areas of health covered and few instances of governments trying to bring privatized health services back into the public sector; an implicit assumption of Canada's trade agreements is that new services not already listed in reservations will not be covered and that Canada's sheltered system of publicly-funded health care will shrink rather than grow in the future (Crawford, 2006).

19 Concerning health care in the context of Canadian-European trade, it is worth recalling that CETA differed from NAFTA, GATS, and most other negotiations in that it was with a jurisdiction (the EU) that had welfare states that were typically more developed than Canada's, with environmental and labor activists who were at least as radical and as mobilized as those in Canada. When negotiations stalled, the Canadian and European governments could have pursued a different, more minimalist strategy that focused upon reducing trade restrictions and providing clearer carve-outs for essential medical services, a strategy that was attractive to many civil society groups and political actors within both Canada and Europe. It also would have been the most consistent approach with the pre-2006 rhetoric about healthcare being “off the table” of international trade negotiations. Nevertheless, the Harper government, which prided itself on signing trade deals and promoting investment, was willing (indeed anxious) to maintain at the center of the CETA bargain the strengthening of investor-state provisions (giving corporations the right to sue governments) as well as helping specific interests in the mining, manufacturing, and beef sectors (Smith, 2017; Van Harten, 2015). This was consonant with general trends in the international trade agenda, so it was much easier for the Liberals to add a few “progressive” clauses and side-agreements to the neoliberal agenda rather than try to negotiate a reversal. A preference for policy

“coherence“ between trade and investment law and domestic health rather than policy “autonomy” was probably also ideologically more congenial to the centrist Liberals than a progressive resistance to this aspect of globalization.

03. Implications of the “Progressive” Trade Agenda for Drug Policy and Pharmacare

20 By the time that the Liberals had returned to power in October of 2015, they were prepared to keep contentious items like stronger drug patents and investor-state dispute settlement in CETA, but to balance and soften their impacts through a NAFTA-style strategy of having additional legitimating clauses for international trade lawyers to litigate, principally in the form of environmental and labour side-agreements. As a way to promote beef and auto exports and avoid losing market share, while at the same time temporarily assuaging trade critics, it was a successful strategy; but in the health care sector (which is only lightly touched by the side agreements) consumers will be mostly negatively impacted. The amount Canada's economy could benefit if all the tariffs on EU imports into Canada were eliminated was pegged in 2008 at about $850 million annually (McGregor 2016). Yet the cost of extending drug patent protection by two years (i.e. to recover time lost during the regulatory approval process) is estimated to be in the range of between $795 million and $1.95 billion annually (Lexchin et.al 2014). In other words, the benefits to Canadian consumers of CETA will be wiped out by higher drug prices, once the impact of patent protection is fully felt in the mid-2020s. (On the producer side, the principal beneficiaries appear to be US and EU drug companies: Canada’s chronic trade deficit in pharmaceuticals rose sharply after the CETA was signed in October 2016, to $8.7 billion in 2017 and $8.5 billion in 2018.)

> The federal government has announced that it will compensate provinces for the rise in drug costs for their public drug plans. If this proves to be the case, then instead of Canadian taxpayers paying the additional costs for prescription drugs at the provincial level they will simply pay at the federal level. Importantly, people paying out of pocket for their drugs, or through private insurance, will not benefit from this compensation. Estimates are that 13% of the Canadian population is either uninsured or underinsured for prescription drug costs ... and that cost-related nonadherence is 35% among people with low income and no insurance. ... People with no drug coverage and paying out of pocket are usually people with minimum wage jobs ... and are often the least able to absorb increases in prices. No compensation will be given for either co-payments or deductibles paid out-of-pocket by insured patients covered by a public drug plan. Therefore, whatever compensatory measures the federal government is committing to, to help provinces offset the predicted cost increases, will not help those who will be the most impacted by these increases. (Ibid., 7).

21 It has been estimated that having a new Universal prescription drug plan could save Canadian consumers as much as $4.2 billion per year, but approximately a quarter of that amount will be offset by losses due to longer patents contained in our international trade and investment agreements. The rationale? According to Canada’s Research-Based Pharmaceutical Companies, it is imperative to change Canada’s currently “uncompetitive” IPR regime. It was also deemed important to secure access for Alberta beef and Ontario autos (up to 100,000 vehicles per year) to the European market. This may prove to be a politically acceptable and reasonable balance, necessitated by the location of most major pharmaceutical companies within the

borders of our two largest trading partners, and the need to foster more applied research in the pharmaceutical industry within Canada. There is no evidence, however, that previous concessions to the pharmaceutical industry since the Mulroney era have resulted in increased research & development spending in Canada. It is also important to bear in mind that currently, "competitive" patents do not represent a consensus among economists as to what represents the optimal patent, since (1) much pharmaceutical research is parasitic upon more basic research funded by Government, (2) shielding companies longer from the competition is not necessarily better for innovation; (3) different countries and different sub-sections of the population have extremely different welfare impacts, e.g. there is a strong preference for cheap generics in poor countries and among poorer seniors in wealthy countries (Braithwaite and Drahos 2000, 386-390).

22 As a 2010 overview of the literature concluded, the elusiveness of a solution to the patent length problem “lies within patents' contradictory nature; to promote innovation by excluding others from using the knowledge that is otherwise free and inexhaustible, which prevents them from further building on the existing knowledge for the possible benefit of society” (Kramming 2010, 31). The most significant analysis of the effects of international trade and trade agreements upon optimal patent length is that of Michele Boldrin and David K. Levine, who conclude that generally speaking, the socially optimal amount of protection decreases as the scale of the market increases. (Boldrin and Levine 2013, 3). If they are correct, then we are indeed confronted by a paradox: the pure theory of trade suggests that we shorten patent lengths in a globalizing economy, because of improved communications, free trade agreements, etc. That means that it should take less time to recoup innovation costs and make a reasonable profit than it used to. Yet we must lengthen drug patents because modern 'trade' agreements include such impurities as patent protections for industries in which we and/or our trading partners feel there is a comparative advantage.

23 Of course, the Boldrin-Levine thesis has been challenged: in one empirical study of the effects of patent extension following the TRIPs Agreement, David S. Abrams found "an increase in innovation [at least in the biotech industry] due to patent-term extension following TRIPS" (Abrams 2009, 1613). It may be that the increasing size of markets due to globalization and free trade agreements makes the recuperation time for investments shorter and therefore the patent length should be shorter, but that product life cycles and R&D costs in the pharmaceutical and biotech industry may mean that they constitute an exception. Nevertheless, the official rationale for the existing post-TRIPs agreements, which have involved further extensions of patent length and other provisions such as data exclusivity that prevent cheaper generics from entering the marketplace, is not framed in terms of any such "exception". The content of TRIPs is better explained by the power of the U.S. government, and the governments of other signatories such as Europe and Canada, and the power of pharmaceutical, film, and high-tech industries influencing those governments. A progressive economic nationalism should question whether increasingly restrictive intellectual property regimes are being created for the sake of health care. And the media and general public need to be reminded of the general point that inserting stronger intellectual property rights into international law is not “free trade” and does not unambiguously guarantee greater global welfare.

04. Implications of the “Progressive” Trade Agenda for Health Care Reform: The Issue of Reversibility

24 At its most fundamental level, the problem posed by the intersection of international trade regimes with domestic health care systems stems largely from a contradiction between their respective presumed logics: international trade rules tend to be negotiated, then written and interpreted on the assumption that increasingly liberalized markets are more efficient and better for growth and consumer choice and welfare; and that they should therefore be encouraged to grow and should be entrenched. Health economists and medical experts, on the other hand, tend to share most citizens' view that health care utilization should be based on patients' needs, and based on citizen equality, and not on market demand and supply. This contrast is bolstered by empirical evidence that private health insurance markets are prone to higher costs and 'market failures' than are single-payer public systems (Arrow 1963; Evans 2003). Trade rules thus carry an ideological bias that not only clashes with the egalitarian view that health care should not simply be for sale but also with the sophisticated view of most health economists that general inefficiencies and welfare losses are likely to result from attempts to "lock-in" market-based approaches to health care reform.

25 For example, 'Payment and Delivery Reform' refers to the payment (or 'free' non-payment) at the point of use versus premiums and/or general revenue and the choice of the delivery system, which can include various kinds and degrees of public, not-for-profit, private, commercial /competitive organizations and structures, involving varying degrees of centralization /decentralization. The tie-in with international trade derives primarily from the potential combination of the general market-style or market-driven nature of many healthcare reforms undertaken domestically with international trade "exemptions" that are typically either constructed narrowly or are written or interpreted to make any commercial elements automatically exposed to international trade rules. The Article 1:3 GATS Exclusion clause states that a service "supplied in the exercise of governmental authority" is not covered by the GATS MFN or NT obligations; and the NAFTA Annex I Social Service Reservation (carried over into the USMC or NAFTA II), which states that all provincial government measures that were in force as of January 1, 1994, are outside the NAFTA rules relating to national treatment, MFN, and some other disciplines relating to local presence requirements for cross-border services and nationality requirements for senior managers. The difficulty with the former is, as Markus Krajewski has written, that dependence of the scope of governmental authority on the “circumstances of supply and not on the nature of the service” arguably necessitates a narrow meaning of the clause, and that it is even possible that universal publicly funded health services provided free of charge could be subject to the agreement if hospitals or physicians that are organized on a for-profit basis supply the services competitively (Krajewski 2003, 351-354). As for the latter, even if it is interpreted generously, areas that fall outside the traditional features of the Canadian health law—"medically necessary" hospital services and "medically required" physician services—will likely not be covered.

26 As a result, the current scope of “protections” for health care in international trade agreements preserve *ex-ante* flexibility, but not reversibility. The degree of autonomy

of domestic health care policy from trade law rests largely on three variables: (1) the level of international trade in health and health services; (2) the levels and kinds of international trade litigation and dispute resolution as they relate to health; and (3) the importance of markets in national and international health care reform. Since all of these factors are growing in importance, even countries that freeze their trade commitments relating to health may find their domestic policies increasingly circumscribed by trade policy considerations. Thus, although the optimism of trade agreement defenders may be well-founded when viewed from a static perspective, the protection afforded by exemption clauses and careful scheduling of commitments shrinks with the expansion of market elements in healthcare. Health policymakers will not have the luxury to engage in "business as usual", but rather will need to assess the trade-related risks associated with market-based reform in the future. To better coordinate health and trade policy, officials need to systematically consider the various risk scenarios posed by (1) changes in international trading regime; (2) different models of health care reform; (3) technological change and health service innovations; and (4) the market elements implicit in changing healthcare systems.

27 Healthcare reforms that either privatize health care or that seek to regulate already-private systems most readily incur extensive trade treaty regulation. It should not be taken for granted, however, that trends in healthcare lead necessarily toward greater privatization and therefore greater exposure to trade treaty obligations. Table 2 summarizes some major trends in healthcare as described in Michael Decter’s 2002 book *Four Strong Winds*: a couple of these trends (growing Public Expectations and Financial Pressures –the second and fourth rows in the table) are often interpreted to suggest the need for increased market choice and competitive delivery, but that is highly contestable in different contexts. Moreover, neither the accent upon prevention nor technological change (the first and third rows of the table) points unambiguously toward either the likelihood or the desirability of using private markets. What this 'big picture' of healthcare trends suggests is that (1) health care reforms undertaken in response to these pressures should be formulated with possible exposure to trade rules in mind; and (2) trade treaty obligations that are intended to foster and then lock in market-based solutions to health care problems ought to be used very carefully and selectively, lest they prove counter-productive to several desired outcomes.

Table 2. Healthcare Trends: Market–Based Solutions?

Dimension of Change	General Observed Trends	Market elements
From Curative / (Treatment) to Prevention (Outcomes)	**more Measurement of Outcomes, Regionalization, Integration of services**	**? Prevention is better undertaken with a strong public health/primary care foundation**
Public Expectations (Speed, Quality, Appropriateness)	Baby Boom Consumers’ Needs and Choices (and Spending Power)	**X (Some desire for extra-billing and/or competitive delivery found in upper-income brackets)**
Technological Change (Digital & Genomic)	Less invasive treatment options (e.g. drug and gene therapy) faster/better communication/ information	**? Digital health innovation may be helped by markets, but administrative costs lower and coordination better in the public system**
Financial Pressures (Global Competitive Pressures, Value for Money)	**Restructuring, Integration, De-centering of Acute Care Hospital, greater emphasis on home care, nursing, etc.**	**X (Austerity may trigger privatization but that may raise costs, not lower them.)**

Source: Decter, M.B. (2002)

28 A renewed desire for policy autonomy could make potential alignments possible between "progressive" and "economic nationalist" trade policy agendas. Like economic nationalists, progressives can see diminishing gains from trade liberalization, coupled with rising costs in terms of trading regimes' constraint on universal and affordable healthcare. But as long as progressivism is yoked to the conventional neoliberal trade agenda, as it is in the current Canadian Liberal trade policy, the potential for such a rapprochement (or a "progressive economic nationalism") is quite limited. From this perspective, the Liberal government's approach to saving the CETA in 2015-2016 may have been a missed opportunity: Canada was negotiating with a partner whose various welfare states and recalcitrant pressure groups had as much to gain from more categorical protection of health care as Canada's did, yet a broader or more categorical carve-out was not seriously considered.

05. Conclusion: From “Democratic Autonomy” to “Progressive Neoliberalism” in Health and Trade: Is There a Way Back?

29 Globalization doesn't just call for constraining government, but for enabling the government to respond locally to new contingencies; yet trade and investment agreements like CETA and the CPTPP "commit citizens to certain forms through which politics is practiced and institutionalize a legal incapacity to act in a variety of economic matters. These features...are premised on a distrust of democratic institutions familiar to students of constitutional theory" (Schneiderman, 2008, 17).

30 Although the “Governmental Authority” exemption still features prominently in Article 1:3 of the GATS, and the NAFTA Social Service Reservation still arguably shields health services that are largely publicly financed, these types of clauses feature less prominently in more recent bilateral and plurilateral agreements, while investor

dispute settlement and protection of intellectual property rights have become standardized and entrenched. Canada has chosen to add "progressive" measures regarding labor and the environment onto a wider and more intrusive regulatory framework aimed at constitutionalizing the neoliberal trade agenda, rather than promoting a less intrusive regulatory scheme with clearer carve-outs for domestic policy areas such as health.

31 One reason for questioning this strategy is similar to Andrew Lang’s objection to projects of institutional coherence between trade and human rights regimes: “such projects risk turning our attention away from other kinds of debates and discussions which are an important precondition for productive re-imagining of global trade governance in response to contemporary challenges” (Lang 2011, 137). By choosing policy tools and legal instruments that force ‘coherence’ between trade and health, we may be compromising the integrity and legitimacy of each: as when we ask WTO dispute settlement bodies to make rulings based on non-WTO Law, or when we discover that health policy space is more circumscribed by commitments to intellectual property and investment regimes than we had previously thought.

32 Related to this critique, and to some extent underpinning it, is simply that there are diminishing economic returns to trade liberalization, a fact pointed to by an increasing number of analysts (e.g. Rodrik 2018; Autour et al. 2016). The biggest and most unambiguous gains from trade for consumers were obtained by traditional agreements that eliminated tariffs. (Remaining tariffs are now very small for most traded goods.) The rationales for most recent negotiations, however, are other factors such as competition for capital; geopolitical concerns (such as the Obama rationale for the TPP); the desire to maximize exploitation of intellectual property rights because that is where the comparative advantage of the United States and Europe lies; and fear of trade diversion. A common thread underlying each of these rationales is lobbying by investors and multinational corporations who are the biggest and most immediate beneficiaries of the new trade agreements: “In all these areas, the TPP and TTIP seemed to be not so much about liberalism as about corporate capture” (Rodrik 2018, 212). Official statements and public discussion often obscures this fact by continuing to use the “growing pie” metaphor, often because well-meaning economists and government officials are afraid of a return to protectionism.

33 The threat posed by the populist conservative variant of economic nationalism is not just that of protectionism, but of actual trade *perversity*: the continued strengthening and entrenchment of trade-related investment and intellectual property rights, coupled with an erosion of commitment to trade liberalization in goods and services. For all of President Trump’s talk of “taking our country back” and restoring national sovereignties, there has been little or no talk about weakening the legal frameworks that have been established for the sake of American and European investment and intellectual property regimes. Protectionism is ironically focused on the traditional domains of natural resource and manufacturing exports—areas where historically the actual welfare gains of the international trading system have perhaps been the clearest.

34 It was already clear in the first decade of this century that standard “governmental authority” and “social service” exclusions in trade agreements would not in themselves insulate healthcare policy and healthcare reform from trade treaty obligations that would make healthcare reforms either less effective (e.g. through higher drug prices) or less flexible (by undermining policy reversibility due to “locked” in investment and

IP obligations). This suggested the need to more fully coordinate trade and health and social policy, by weighing the potential costs of trade treaty obligations triggered by experiments in market-style or market-driven healthcare policies (Crawford 2006). Although the recent populist backlash against economic integration in Europe and North America threatens us with trade policy perversity, it also has a rational economic basis (i.e. in declining economic returns from trade liberalization). It also has a solid respectable basis in legitimate democratic norms. As Rodrik notes,

35 "The notion of fair trade is much derided by economists who view it as a thinly disguised cover for self-interested protectionism. But it is already enshrined in trade laws (in the form of antidumping and safeguard remedies), although in a skewed, corporation-friendly way. So rather than abandon the fair trade concept, we should broaden it, as it exists in trade law, to include *social* dumping. Just as countries can impose duties on goods that are sold below costs, they should be allowed to restrict imports that demonstrably threaten damage to domestic regulatory arrangements... I would argue that this would not open the trade regime to more protectionist abuse than current antidumping practices already do! The benefit of thinking about fair trade along these lines is that it allows the drawing of a clear line between trade flows that threaten legitimate domestic political arrangements and those that don’t” (ibid., 231).

36 Health care advocates who used to hold out hope for “carve-outs” from trade agreements may wish instead to embrace a progressive strategy that operates on two tracks. First, from the domestic or micro-level (e.g. Canadian provincial health policymakers) they should carefully weigh the risk that market-style reforms may be difficult to reverse under existing NAFTA, WTO, and bilateral investment law. This may require a greater degree of mobilization and pressure at local and provincial levels than has been evident thus far. Second, on the international level, they should seek to harness the new openness to economic nationalism by challenging the prevailing wisdom on drug patents and by negotiating rules against “social dumping” (i.e. trade flows that harm domestic health policies). Recent trade agreements such as the CPTPP have further empowered corporate actors by involving them not only extensively in negotiating committees, but also in various regulatory harmonization committees aimed at implementing the agreement in several areas affecting health, such as alcohol and tobacco, recognition of medical credentials, regulation of chemicals, and food labeling. Since the argument for "Health in All Policies" has received a powerful boost due to the coronavirus pandemic, perhaps national health ministries and medical and scientific communities could be similarly empowered in trade governance circles to protect and advance health care objectives such as lower drug costs and broader health insurance coverage. That may be a more promising way forward than simply putting a progressive veneer on a fundamentally neoliberal trade strategy that still serves domestic producer interests far more effectively than those of consumers, including the consumers of health.

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NOTES

1. See Chaoulli v. Quebec (2005); Allen v. Alberta (2015); Cambie Surgeries Corporation v. British Columbia (Attorney General) (2018); McCreith and Holmes v. Ontario (2007).

2. Chaoulli v. Quebec (Attorney General), 2005 SCC 35 (CanLII), [2005] 1 SCR 791, <http://canlii.ca/t/1kxrh>, retrieved on 2020-10-30.

3. Cambie Surgeries Corporation v British Columbia (Attorney General), 2020 BCSC 1310 (CanLII), <http://canlii.ca/t/j9kpw>, retrieved on 2021-01-07.

4. See https://www.canada.ca/en/employment-social-development/services/labour-relations/international/agreements.html

ABSTRACTS

From 1995 to 2006, Canadian trade policy purported to insulate the Canadian health care system from the effects of trade liberalization, largely through reliance upon key general exclusion clauses in the NAFTA and the GATS and other legal strategies. During the Conservative years 2006-2015 the government de-emphasized these strategies, and (more importantly) the international trade agenda increasingly emphasized investment promotion and patent protection. When the Liberal Party returned to government in 2015, personal, structural, and ideological factors all pointed to the retention of the neoliberal trade agenda, but one which was legitimated by more 'progressive' features, such as side-agreements. This paper traces the evolution of 'progressive neoliberalism' in the trade-health interface and argues that we need to recognize the inherent limitations of an approach that preaches harmony and coherence between domestic health care and international trade law.

De 1995 à 2006, la politique commerciale canadienne visait à protéger le système canadien de soins de santé des effets de la libéralisation des échanges, en grande partie en se fiant aux principales clauses générales d'exclusion de l'ALENA et de l'AGCS et à d'autres stratégies juridiques. Pendant les années conservatrices 2006-2015, le gouvernement a mis l'accent sur ces stratégies et, plus important encore, le programme commercial international a de plus en plus mis l'accent sur la promotion des investissements et la protection des brevets. Lorsque le Parti libéral est revenu au gouvernement en 2015, des facteurs personnels, structurels et idéologiques ont tous mis en évidence le maintien du programme commercial néolibéral, mais qui était légitimé par des caractéristiques plus « progressistes », comme les accords parallèles. Cet article retrace l'évolution du « néolibéralisme progressiste » dans l'interface commerce-santé et soutient que nous devons reconnaître les limites inhérentes d'une approche qui prêche l'harmonie et la cohérence entre les soins de santé nationaux et le droit commercial international.

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Mots-clés: politique commerciale, politique de santé, néolibéralisme progressiste, droit des investissements, politique pharmaceutique
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